STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS
APPLICATION FOR EXEMPTION FROM CON PROCESS
Form 2010

All persons who are requesting an exemption from the Certificate of Need process under the requirements of Connecticut General Statutes, Sections 19a-639(d), 19a-639(e), 19a-639b and 17a-678 must complete this form. Please submit the completed forms to the Commissioner of the Office of Health Care Access, 410 Capitol Avenue, MS#13HCA, P.O. Box 340308, Hartford, Connecticut 06134-0308.

SECTION I. APPLICANT INFORMATION

If there are more than two Applicants, please attach a separate sheet of paper and provide additional information in the format below.

	Applicant One	Applicant Two
Full Legal Name		
Doing Business As		
Name of Parent Corporation		
Mailing Address, if Post Office Box, include a street mailing address for Certified Mail		
Applicant type (e.g., profit/ non-profit)		
Contact person including title or position		
Contact person's street mailing address		
Contact person's phone #, fax # and e-mail address		

SECTION II. GENERAL PROPOSAL INFORMATION

a. Proposal/Project Title (i.e. use applicable state licensure categories):

b. Location of proposal (Town including street address):

c. List all the municipalities this project is intended to serve:

d. Estimated starting date for the project:

e. Provide a brief description of the proposal in the box below. Use a separate sheet if necessary.

SECTION III. ESTIMATED CAPITAL EXPENDITURE INFORMATION

Estimated Total Capital Expenditure:

SECTION IV. EXEMPTION INFORMATION

I may be eligible for an exemption from the Certificate of Need process because of the following: (Please check the boxes that apply.)

Section 19a-639(d), C.G.S.

This is a Community Health Center which:

- ☐ is proposing a capital expenditure which does not exceed one million dollars provides only primary care or dental services and either
- ☐ 1/3rd or more of the cost is financed by the State of Connecticut (supporting documentation attached);
- ☐ is receiving funds from the Department of Public Health (supporting documentation attached); or
- ☐ provides services in a medically underserved area or in a health professional shortage area with proof attached.

This is a Federally Qualified Health Center Satellite which:

- ☐ is part of a federally qualified health center with proof attached
- ☐ provides only primary care or dental services
- ☐ provides services in a medically underserved area or a health professional shortage area with proof attached.

Section 19a-639(e), C.G.S.

This is a school-based clinic, which is:

- ☐ licensed or will be licensed by the Department of Public Health (DPH)
- ☐ approved by the DPH as meeting a standard model for a comprehensive school-based health clinic
- ☐ proposing a capital expenditure not exceeding one million dollars located entirely on the property of an existing school site.

Section 19a-639b, C.G.S.

☐ This proposal is intended for a non-profit facility, institution or provider to fill a specific service need as identified by a state agency or department which:

- ☐ has a capital expenditure that does not exceed one million dollars, **and**
- ☐ has received an endorsement from the Commissioner, executive director, chairman or chief court administrator of the state agency or department confirming the service need. (Supporting endorsement attached)

Section 17a-678, C.G.S.

This is a proposal to close a service delivery system gap in the statewide substance abuse service delivery plan which:

- ☐ is a community agency operating a program in a state institution or facility
- ☐ is a nonprofit community agency operating a program in a state institution or facility and is receiving funds from the Department of Mental Health and Addiction Services (DMHAS)
- ☐ is a nonprofit substance abuse facility and is receiving funds from DMHAS
- ☐ is submitting a letter from the Commissioner of DMHAS that is attached with proof of DMHAS funding and confirming the above.

SECTION V. WAIVER/ EXEMPTION AFFIDAVIT

Applicant:

Project Title:

I, _____, _____,
Name of the authorized representative *Title*

of _____, being duly sworn, depose and
Facility Name
state that said facility complies with all of the criteria: (*Check One Only)*

- ☐ Stated in 19a-639(d) of the Connecticut General Statutes (FQHC/CHC)
- ☐ Stated in 19a-639(e) of the Connecticut General Statutes (School-based clinic)
- ☐ Stated in 19a-639b of the Connecticut General Statutes (Non-Profit)
- ☐ Stated in 17a-678 of the Connecticut General Statutes (DMHAS)
- ☐ Stated in 19a-639c of the Connecticut General Statutes (Replacement equipment Waiver)

☐
_____ _____
Signature Date

Subscribed and sworn to before me on _____

_____
Notary Public/Commissioner of Superior Court

My commission expires: ☐_____